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AUTHOR	Cunningham, Luvern L.
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ABSTRACT

Clinical education is learning in a field setting where the emphasis is on knowledge application, feedback, appraisal, and reapplication. Mid-career administrators can improve management, communication, and political skills in clinical settings where close observation of performance, judgments about performance, and prescriptions for improvement are provided by the clinical team. (Author/DW)

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MID-CAREER STUDY FOR SCHOOL ADMINISTRATORS: PROGRAMS AND PROBLEMS

by

Luvern L. Cunningham
Professor of Educational Administration
The Ohio State University

Preamble

An enormous investment of dollars and energy is being made in staff development, mid-career and otherwise. Estimates of the nation's total expenditure for staff development in education run into billions of dollars. We need, as leaders in educational institutions, to examine carefully the quality and the productivity of that investment. There is reason to believe that much of what we do in the name of staff development, in-service training, or continuing professional education is less than effective.

Staff development, including mid-career education, is highlighted at every turn in the road. Local school districts are establishing programs, professional associations have several mechanisms in place including conferences such as this, universities are stepping up their efforts and are much more innovative than in the past, state departments of education are designing their own ways of improving human performance, special agencies are being developed by professional groups such as the National Academy of School Executives, local academies for staff development are cropping up here and there, teaching improvement centers are other examples. One could go on and on.

The private sector, too, has its display of learning opportunities. The American Management Association, The School Management Institute in

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Ohio, The International Graduate School of Education out of Cherry Creek, Colorado, are examples. Foundations, too, are in this business. The Kettering Foundation and the Ford Foundation are two that are well known. Rockefeller and Carnegie have invested in intern programs and other smaller foundations are alert to this need as well. All in all there is a cacophony of staff development sounds. And there is a broadly differentiated set of institutions, agencies, businesses, and governments involved in staff development business.

Despite these efforts (most of them marked with good intention and nobility) we're still falling far short of elevating the level of human performance so that it is equivalent to demands and needs of our time. There are probably several reasons why this is the case. Some of them are as simple as designing staff development programs upon improper bases or assumptions. Others are unrealistic in other terms. So today I would like to talk about some of those assumptions, examine some of the existing formats, and make a few suggestions about how I think that our investment in staff development, especially at mid-career, can be more beneficial.

Education at Mid-Career: A Few Examples

Several attempts have been made to provide sound opportunities for practicing administrators to have extended learning opportunities at mid-career. There are reasons why we have thought it important to allocate time and resources for improving our capacity to perform. Some of these grow out of the feeling that many practitioners need relief and rehabilitation. Others feel that they need a chance to recharge their batteries, to get away from it all for awhile, to put their feet up and think about

their problems. Others sense that there are areas of knowledge and skill development which need attention in their own regard.

School districts, those which are reasonably enlightened, recognize the significance of this need and on some occasions have put in place programs of their own, or systems of support which would allow people to engage in a rich variety of self-development activities.

At The Ohio State University we have had substantial experience with two mid-career program formats. One of these is for practicing administrators, many of whom have been principals. The other is The National Program for Educational Leadership which has involved the Department of Education in North Carolina and six major universities. As a result of our work with these two programs we have learned about problems and issues in mid-career education. We have witnessed the questions which arise when persons successful in another profession or occupation shift over into education. We have witnessed as well the problems and issues which are associated with leaving one's job for six months of two years, moving into a campus setting, adjusting to that new environment, and the anticipations that go along with re-entry back into the job situation.

Both the mid-career program for practicing administrators and the NPEL program have encountered a common problem. It is that is it often difficult for intense, busy, harried executives, whether they be from education or some other field, to suddenly find themselves in an environment where many opportunities for self-development are available but little counseling or direction exists in that regard. It has been our philosophy at Ohio State that each individual should be substantially in command of his own staff development programming. Thus, when people arrive,

they are given many learning and skill development options, some counseling in regard to those options, but the responsibility for final choices resides essentially with the person at mid-career.

Some people can handle this freedom well. Others stumble, make false starts, and misuse substantial amounts of their time. This seems to be true of other programs, especially intern programs. The Washington Internships in Education, The Rockefeller Fellowship Programs, the several leadership training instituttes sponsored by the Office of Education, The Consortium Fellowship Program financed by the Ford Foundation, -- each of these has program participants who have encountered trauma associated with program entry, program exit, and job re-entry.

The Concept of Clinicianship

One of the premier learnings that has grown out of our work at Ohio State is that, whatever our program, it must deal fundamentally with the problem of knowledge possession and knowledge utilization. We have discovered, much to our chagrin, that possessing knowledge is in itself insufficient. People need knowledge application skills. We have proceeded in the past on the improper assumption that if we know something we can act on the basis of that information, data, or knowledge. That is not the case. There are many skills which we need to refine if our knowledge possessions can be translated into knowledge applications. For that reason I would like to share with you some of my thoughts about clinicianship, clinical settings, and the kirds of resources necessary to make education for professionals effective.

Clinical education, as I define it, is the process of learning in field settings where the sustaining emphasis is knowledge application,

feedback, appraisal, and reapplication directly to affect improvements in human performance. Several references will be made to experience at The Ohio State University with two programs involving persons at mid-career. One of these is the National Program for Educational Leadership supported by the U.S. Office of Education; the other is the Mid-Career Program in Educational Administration supported by the Ford Foundation.

NPEL Fellows were (and are) non-educators with interests in educational leadership. The Mid-Career Program in Educational Administration, on the other hand, is for seasoned administrators recruited from the establishment. Mid-Career Program participants are chosen, most often, from principalships or assistant principalships and occasionally from the ranks of assistant and associate superintendents, for six months of campus-based, mid-career education. Field experience was an important part of NPEL; field experience has been much less central-stage, until recently, in the Mid-Career Program in Educational Administration. Clinical experiences were rare in both.

Over the past several years the profession of education has adopted words like "clinic," "clinical experience," and, more recently, "clinicianship." The utilization of terms from the medical lexicon is a mixed blessing. Those terms do, however, communicate and thus we have found ourselves using them over and over again in our work at Ohio State. (We are searching for more appropriate language to carry our meaning regarding improved ways to bring knowledge to bear upon education or training in field settings.) Clinics, in medical usage, are places where diagnostic and prescriptive activities occur. Health clinics are locations for the application of knowledge to human health problems. Usually clinical ser-

vices are applied to individuals. Indeed, people from all over the world seek the services of certain clinics. The Mayo Clinic in Rochester, Minnesota, is one example. The Menninger Clinic in Topeka, Kansas, is another. At these and others like them, advanced systems for knowledge retrieval and application are clustered. The clinic service includes a diagnosis, prescription, application, feedback, re-diagnosis if necessary, adjusted prescription, application, and feedback. Each decision point is a knowledge application point.

There are no absolute counterpart capabilities in education, either for individuals or institutions. We cannot physically move an institution, e.g., a junior high school, into a social science Mayo's. We can more easily move our social science understandings into the field. We can diagnose, prescribe, apply, and respond to feedback. We can collect and store information in one setting that may have value to others in similar circumstances. And we can simultaneously blend diagnostic and prescriptive activities with the preparation of a variety of professionals, especially prospective administrators and policy scientists.

A Commentary on Experience

As a prelude, I would like to describe briefly one set of clinical experiences which involved five NPEL Fellows and myself. The setting was Detroit. The professional responsibilities were a part of our work with the Detroit Education Task Force, a citizens' group engaging in a new form of public problem solving. The clinical activity involved a serious attempt at peer criticism, observation, debriefing, role playing, and reappraisal.

The Detroit experience, for me and for the five NPEL Fellows, was a clinical experience. The NPEL Fellows, through their work in Detroit, became involved with an exceedingly diverse assembly of laymen interested in education. They also came to know and work with a wide range of public school officials, principally administrators and staff members of the Detroit Central Board of Education. We lived in the city during much of 1973-1974, and had an opportunity to learn, firsthand, of the richness and intensity of Detroit urban life.

As an administrator of the National Program for Educational Leadership, as well as the principal staff officer for the Education Task Force, it was my responsibility to blend the learning expectations for Fellows in NPEL with the staff needs of the Education Task Force. We were doers and learners, simultaneously. For each of us our responsibilities were marked by diversity as well as excitement. The experiences were at once intellectual and visceral. We came to know the problems and issues confronting the Detroit Public Schools, but we also discovered our own strengths and weaknesses (personal and professional) as a consequence of our encounter with those issues and problems.

The six of us designed and participated in a "learnings" seminar during the year. For several hours each week, usually on Thursday evenings, we focused the seminar on problems before the Task Force and on our own individual Task Force responsibilities. Over time, we developed our capacities to deal clinically with the issues of education as well as our own performance and behavior. The seminar was used as a mechanism for personal criticism and for assessing our learning. When one of us had a major responsibility with the Task Force, especially

one that involved public performance, we tried to anticipate reactions to our performance as effectively as we could. We went over written materials thoroughly. We debriefed immediately after public presentation, and located those aspects of our behavior that warranted special attention. Similarly, we reanalyzed the substance of written materials and tried to improve them when they came up for subsequent presentation and review. The work (and learning) setting allowed enough free time for detailed professional and, on occasion, personal criticism.

In my judgment, the seminar was of unusual value. I can speak on the basis of my own experience and my own estimate of its meaning for me. And I believe that my sentiments are those of the NPEL persons there. Preparation for leadership will be incomplete until we insist that field-based learning situations meet two criteria: (1) the setting allows for the assumption of solid, fully-developed responsibilities with accountability spelled out; and (2) the location is congenial to developing strength among the members of a specially designed collegial learning community, where the bases for criticizing the performance and behaviors of the persons who hold membership in this collegial community are clear.

The words "clinic" and "clinical" are used much too freely. I am, and have been, guilty of those transgressions. The terms are applied to a range of experiences. Often they are used as synonyms for internship or field experience. I want to distinguish my use of those terms (clinical and clinicianship) from other meanings.

To repeat, a clinical experience in a training sense must include close observation of human performance, judgments about that performance, and prescriptions relative to its improvement. It is sustained through

knowledge application. The clinical experience should involve a clinician and a learner or a set of clinicians and a set of learners who have rather clear differentiations in their roles, but who associate essentially as learning colleagues. Clinicians are both diagnosticians and prescribers. Clinicians and learners are tied together by a common devotion to problem solving.

It is useful, for me at least, to distinguish between clinical settings and settings for internship or field experience. Normally, an intern is guided in his learning development through field supervision and training center supervision. Usually, a setting for the internship is located, a field supervisor is identified and named, a time frame for the experience is determined, and the supervision of the learning program sponsor is specified. Sometimes the intern and/or field experience is observational. Sponsoring agency supervisors and field supervisors, as well as persons in training, find such broad observational experience useful. Increasingly, intern and/or field experiences include more "hands-on" responsibility. Settings are located where in-depth assumption of responsibility is possible which stands in sharp contrast to what were essentially observational locations in the past. In most cases, however, learning outcomes fall short of those expected in a genuinely clinical environment.

Some Observations About Skill Development

A clinical setting should be rich in practice options. The clinical supervisory and instructional team should be gifted in the utilization of observational and feedback techniques. The clinical learning group,

i.e., students, sponsoring agency supervisors, and field supervisors, should join in the selection of skills to be developed, as well as the cognitive areas to be strengthened. (Those choices should be made after a reasonable period of work in the field.) A range of clinical staff field observations could be designed which would permit the identification of those skills as well as cognitive areas to be developed.

Two skill areas are reviewed briefly in the pages that follow. They are only two examples; many others could have been selected.

Communication skills

It is reasonable to expect that most persons at mid-career (as well as those who may be entering preparation) will bring to a clinical setting substantial skills in communication. It is reasonable to expect that a person can write clearly and concisely. It is reasonable to expect that a person can speak with clarity and convey meaning accurately. It is not reasonable, however, to expect each person in training to bring the sensitivity, flexibility, and dexterity required of the panoply of communication demands that are embedded in many settings. Campus-nurtured and developed skills may wilt and fade in the face of field requirements. Therefore, it is right and proper to expect the clinical setting to provide practice options that will allow the development of new capacities or improved levels of communication performance. Clinical teams should include persons with talents sufficient to pass judgment upon the effectiveness of communication behaviors, as well as to prescribe in their regard using the best knowledge available.

(In Detroit, we are reminded every day of the fragile nature of communication. We are brought up short repeatedly with the discovery

that words carry different meanings to different people. We encounter the affective or emotion-producing properties of data. We are startled when data elicit diverse responses within heterogeneous assemblies).

If a mid-career person in a clinical setting is required to write a position paper or some other substantive document, that statement should yield to critical analyses which transcend those normally available. Criticisms should be provided by a range of observers, in many cases including persons beyond the boundaries of the formal clinical learning team. In settings marked by socio-economic, racial and ethnic diversity, criticism should be sought from persons who reflect that diversity. Both written and oral forms of communication should be placed under such scrutiny.

Listening skills are as important as speaking or writing. In highly charged settings, or even in those that are less volatile, quick word exchanges lead to responses that are often poorly informed. Leaders must be skillful listeners and sorters. They must be patient to hear others out. They must sift and sort with dexterity. They should, in many situations, employ playback techniques to those who have issued statements, or soliloquies to them. They should, as we all know, look beyond content. They should be able to anlayze communication of which they are not a part and garner insights through such observations.

Most of today's leadership settings, particularly those inhabited by school superintendents, state commissioners of education, federal officials, university presidents, and other highly visible administrative figures, are in the public eye. Persons who occupy those posts are confronted frequently by television and radio reporters. Following board meetings or other public events, or even the sanctity of an office, microphones and cameras are thrust in the faces of leaders. They are asked to

respond to questions with little or no opportunity for preparation. A clinical setting should provide opportunities to test learner capacities to respond in such situations. If the clinical settings do not contain these skill-training options, then simulations should be designed so that those communication skills can be appraised and strengthened. The clinical team, through simulation, could record behavior, make judgments about it, feed back those observations, redo the simulation, and engage in a definitive skill development exercise.

Skills are needed in working with radio and television personnel, obviously. But leader relationships with newspaper reporters are equally important. There are skills that sharpen a leader's capacity to work with the press. For example, the use of precise terms, recognizing the affective properties of what is said, brevity as distinct from wordiness, optimism as distinct from despair, generalizations as distinct from particulars, directness rather than evasiveness, and choosing language for heterogeneous rather than homogeneous audiences. When leaders, especially in settings marked by diversity, use poor words they should be told. When they are not clear they should be told. When they use too many words they should be told. When they are not providing enough detail to support their meaning, that too, should be spelled out.

Feedback has become a household word. It is an important term. Certainly in regard to the behavior of people in training, there should be sustained and repetitive observation of performance and sustained and repetitive forms of feedback. Communication skills should become almost second nature, a part of the person, and improve markedly over what they were before individuals enter into a clinical learning environment. And the collegial fabric (learners and teachers) should be tough enough to support harsh criticism in relation to skill development.

Political Skills

Leadership, administrative, or managerial positions require more and more sophistication in the political skill areas. Although positions may vary in terms of the degree of skill refinement required, the need for such skills is increasingly recognizable across most leadership landscapes. Several questions are worth noting: What are the central, most effective political skills that leaders should possess? How can political skills be assessed? What sorts of clinical settings allow political behaviors to be displayed so that judgments can be made about them? What clinical staff capacities are required to "apply" knowledge of political behavior so that it is reflected in leader behavior?

Each of us is called upon frequently for judgments about others. If we were asked about how well persons for whom we have program responsibilities understand political behavior and how effectively people behave politically, how would we respond? How do persons mobilize others? Do they diagnose? Are they persuasive? Are they gifted in influencing? What mannerisms and actions characterize their persuasive behavior? How adroit are they at moving into vacuums? What bases do they employ for initiating activities? How carefully and upon what bases do individuals choose those to be involved in a mobilization? To what extent is the leader willing to share leadership? How gifted is the person in sustaining an activity? Does the individual lead a set of events to culmination? Is the leader willing to abort along the way? To endure pain in the process? Can the individual clean up the wounded after skirmishes? Is the individual willing to patch and paste a situation together in order to fight another day?

It is easy to list questions. It is much more difficult to locate answers. I would argue that few persons responsible for preparation programs raise such questions nor do many attempt to respond to them programmatically.

Several NPEL Fellows, two site coordinators, and I were involved in a joint field study of leadership and management needs of a suburban school district in the early months of 1972. It is in some respects a story of missed opportunity. The setting was filled with clinical learning potential but we muffed it. We ignored the fact that our being there was a political act and all of us were exhibiting political behavior in the conduct of our work. We failed to recognize the potential of that setting for the appraisal and refinement of our own political skills. And we were not prepared to behave clinically in regard to our work even though we had, either in our midst or at our fingertips, the intellectual resources to do so. In retrospect, it is disappointing to realize how an opportunity was underutilized.

Obviously, these comments about two skill areas are inadequate. A full description of the repertoire of skill areas would be extensive.

Collegiality and Learning to Lead

A field learning opportunity should be based upon the simple assumption that everyone is a learner. A collegial association must be based upon the genuine sharing of abilities. The field supervisor knows things that a sponsoring agency person does not know. Similarly, a sponsoring agency team member knows or has access to data unavailable to the field supervisor. Learners bring to the situation substantial amounts of information themselves and in many cases highly developed skills.

At times learners' skills exceed those of those responsible for constructing and supporting the learner in the field. The ideal collegial community will produce a powerful learning chemistry.

A clinical setting saturated with problem solving opportunities allows the pursuit of two virtues simultaneously. First, if the learners are problem solvers, then solving problems is an asset to the setting; and second, involvement in problem solving is extremely educative in its own right. Thus, the situation for learning should be marked by high responsibility for problem solving and high accountability but with sufficient flexibility to permit introspection, self-reflection, and collegial appraisal of performance.

There should be time for instant replay, for detailed feedback, for informed interpretation, for dialogue and conversations about behaviors. The climate should be open for criticisms to flow among members of the collegial team. Learners should have their day in the sun with opportunities to pass judgment upon the performance of those who have responsibility for their own learning.

For learners in clinical settings who are from education there is a particular phenomenon at work. Most who move into educational leadership posts are former teachers. That past experience has both positive and negative attributes. One of the most severe negative features is that the teacher psyche must be adjusted so that it can become a learner psyche. Former teachers who become administrators come to the administrative job with chalk in their hands. They find it very difficult to jettison the teacher image, the teacher expectation, the teacher behavior and assume the attributes of the flip side. Ironically as it may

seem, it is hard for teachers to become learners. It is not an automatic adjustment. Teachers must learn to become learners.

Obviously, the learners in clinical settings cannot be under human observation all the time. Choices have to be made regarding critical events which display skills and attributes. Persons experienced in supervising clinical education will learn to identify occasions which permit a "natural" opportunity to observe leadership talent and ability. Thus, the points for observation should be chosen judiciously with a view towards displaying a range of leader attributes rather than a single attribute. There are times when only a single talent can be appraised, but more often a panoply of abilities will be in view.

Techniques for recording observations should be employed. Tapes, both audio and video, are obvious possibilities. There are others that call for skilled note-taking. In fact persons in training should employ their own devices for making observations about their learnings. Diaries, if considered thoughtfully, are helpful. "Ten minute club" techniques are powerful, as are other experience summary devices.

The clinical situation yields nicely to debriefing techniques. Debriefing is, itself, a skill that leaders should possess. Debriefings can occur in one-on-one situations or in small groups. If more than one learner is in a particular field setting, then groups of learners, through seminars or debriefing sessions can benefit from group debriefing approaches. Groups of learners can develop confidence in using debriefing techniques independent of clinical staff. Disciplined debriefings, conducted within appropriate guidelines and ground rules, are substantial learning tools.

Prior to the contemporary concern about privacy and its protection,

persons like ourselves were called upon often to write recommendations about people which were used in employment decisions. (The future of that practice may now be in doubt.) Such recommendations were expected to be reliable summaries of what one human being knew about another. Letters of recommendation or statements in placement papers were usually general, lacked specific situational references which would allow a reader to be informed definitively about a range and quality of human performances, did not deal with specific talents and abilities, and were usually strength-oriented rather than weakness-oriented. Few letters of recommendation, or statements in placement papers, contain hard data, as it were, upon which employers can build dependable judgments, especially about rather narrowly defined abilities and capacities. For example, an important leader attribute is the capacity to understand hidden agendas, respond to them, and reflect a pattern of behaviors which is constructed in their regard. The presence or absence of that attribute, particularly in settings marked by complexity, is critical to leader performance. The clinical setting should allow for judgments to be made about that skill. (Similarly, as stated earlier, there should be recording processes which allow an individual to have a self-estimate of his capacities.) And if data are needed in the future to support employment decisions, the clinicians can provide extensive and definitive data about performance.

The Design of a Clinical Education Team

There are few clinical education models in existence. There are examples of experience programs where various configurations of talent are used to support the learner in the field. But none of these, to my knowledge, have been as fully designed and implemented as I believe is

required.

There are several theoretical designs that could be considered. One is to design around people, possibly generalists, who know a lot about the skill and knowledge areas related to leadership. Three or four member clinician groups could assume responsibilities for several learners in one or more clinical settings. The assumption would be that these clinicians would possess talents and attributes sufficient to meet a rather fully-developed set of learner needs. A second design could include a core clinical team with a narrower display of specializations. To extend the team's capacity other resources could be added to meet special learner needs. Resource people could be named as auxiliary members or panels could be convened for special purposes related to skill development and knowledge assessment.

Considerable work should be devoted to designing and testing clinical teams. Key to the formation of clinical groups is the basic understanding that these are instruments for bridging between knowledge and practice. They are intelligence and information conduits leading to improved leader performance. Clinicians would need several talents, not the least of which is skill in brokering knowledge and information.

Earlier references were made to communication and political skills. Certainly clinicians working in the field would have to have access in information and knowledge related to those skill and knowledge areas. The brokerage, bridger, translater, conduit functions are unique functions. And those who choose to design clinical teams should keep these attributes uppermost in their thoughts as they engage in the architecture of clinical education.

Concluding Thoughts

Our Mid-Career Program for Educational Administrators at The Ohio State University has enrolled more than thirty persons at mid-career. The evaluation of the program has been universally supportive of the campus-based setting and the learning options available. Evaluations of the first two cohorts revealed a substantial imbalance between "experience" and "theory" or "knowledge." The mid-career persons are experienced in the extreme but they are devoid of theory, schemes or analysis, concepts, or frameworks as tools for understanding and profitting from their experiences. Campus-based pre-service programs err in the other direction. Obviously, a constructive balance must be achieved. But in striking that balance new clinical capacities will have to be employed if we are to bridge, genuinely, the theory/practice gap.

From time to time I have had direct or indirect responsibility for field experience and/or internship phases of conventional pre-service preparation and, more recently, the experimental National Program for Educational Leadership. In each case, at the University of Chicago, at the University of Minnesota, and more recently, at The Ohio State University, institutional intentions were noble, but at each institution we fell far short of what was required to be effective in clinical education terms. It is not attractive in these times to remark about scarce or ineffectively applied resources. But it is true that we have invested marginally in the clinical and/or field experience phases of pre- and in-service preparation. It is done with the left hand. It is an afterthought.

We should be straight-forward about the resource demands of clinical forms of education. If we are to do the job, smaller numbers will

have to be served by larger and more complex assortments of talent and resources. Leadership needs are so apparent in contemporary society that we should deal seriously with the resource problem relative to leadership education. Society's investment in leadership development has been modest, indeed. It may be that now is precisely the time to do the design work in preparation for a larger future investment in leadership development.